It is important that emergency physicians and other personnel involved in the care of these types of cases establish liaison with the HBO treatment facilities in their communities so that referral to such facilities can be expeditiously accomplished when needed. Contrary to what Coleman noted in her recent excellent review of smoke inhalation[12] —that is, that HBO is "seldom available in time to be beneficial" in cases of CO poisoning—HBO treatment is now readily available in many metropolitan areas. (For example, there are five hospitals in the San Francisco Bay Area which currently have one or more monoplace recompression chambers and additional facilities are expected to become available soon.) Also, as noted by Myers,[7] severely poisoned patients may have dramatic recoveries even when HBO treatment is delayed many hours. The importance of knowing the availability of HBO treatment has been further underscored by recent litigation in which large settlements were awarded to plaintiffs because they were not referred for HBO treatment when facilities for such were locally available.

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Impaired Cognitive Judgment in Relation to the Chronic Use of Anticoagulants

TO THE EDITOR: Last year, a corporation president asked about a possible relationship between anticoagulants and impaired judgment. He had noted that, in several instances, otherwise very competent and experienced senior executives had made surprisingly poor decisions or had exercised remarkably bad judgment. (Even the executives themselves, all men, were appalled and confused by their actions.) Subsequently, it had been discovered that, in every case, the individual executive was taking prescribed anticoagulant medication at the time of judgmental errors.

Cursory inquiry of area physicians suggested no such relationship or knowledge of the correlation. Several other major corporation leaders were contacted and asked to view this issue retrospectively. They were asked to determine what significant examples of poor judgment, if any, had occurred in their companies in the recent years. Nine such incidents were identified and, in reviewing the medical histories of the individuals responsible, six were shown to have been taking anticoagulant medications at the time of the inappropriate actions.

Concurrently, I discovered three of my clients who were experiencing frequent bouts of impotency were using only one medication: sodium warfarin (Coumadin, Panwarfin). In addition, two Air Force officers and five businessmen who were either then taking this same drug or had used it in the past made statements such as, "I felt strangely vulnerable and mentally uncertain," and, "It was like not having both oars in the water." Another said, "Being 63, I wondered if I was already getting senile. I couldn't remember whether I'd actually talked to someone or just thought about it." All expressed concern over resulting sexual dysfunctions. Two indicated more of a reduced libidinal drive as the cause of their unexpected lack of sexual activity rather than the inability to properly function. They reported masturbation not to be a problem while the others claimed they had not attempted it since the onset of the difficulties. (This therapist has never encountered an impotency case before or since these cases in which masturbation had not been explored by the client.) None had ever been tested by a nocturnal tumescence device (NTD) nor had any consulted a urologist, neurologist or therapist.

Another patient, a 64-year-old medical doctor, was already falling into disfavor with colleagues due to occasional surgical errors or poor work before a stroke forced his retirement. These errors reportedly occurred during operations when he needed to react quickly and accurately. In several cases, other surgeons actually had to do postoperative repair work. This had been unheard of

during his first 30 years of practice. A review of his medical history shows that after he underwent his own aortic valve operation he began taking substantial amounts of sodium warfarin. His surgical errors occurred after he was treated with the anticoagulant. He also noted a decreased frequency in sexual activity as well, which may or may not be related to the anticoagulant.

Similarly, a very bright and successful 30-year-old women, a bank officer, who was first seen due to marital problems, began suffering from phlebitis and was immediately started on a regimen of sodium warfarin by her internist. She was strongly encouraged to begin an exercise program which she did not do. She was not taking any other medication, although she had recently ended a five-year period of taking birth control pills. Within three months, she became quite alarmed by what she described as "making dumb mistakes" at work. The mistakes resulted from "snap" or "shooting-from-the-hip" type of decisions. Indeed, she had found that if she thoroughly evaluated the criteria and consequences involved, she could avoid these errors in decision making. She claimed no difference in the frequency of love-making, however.

Literature Review

One study contends that "physicians have, for a long time, failed to note that a patient who is using anticoagulant medication daily has, in effect, been converted to a hemophilia-equivalent state. This change in status requires serious psychosocial adjustment to the chronic use of anticoagulants."[1] Another cautions that if this adjustment be poor, the patient may become restless and moody. Further, he may develop an attitude towards life that is negative and generally, dissatisfied.[2] Indeed, the patient may plunge into a pronounced depression with his functioning at only a fraction of his presickness level. His employability, adaptability to normal community stresses and family life may undergo changes that are profound.

Those of us working in rehabilitative psychology and physiatry are aware of the role body image plays in one's self-esteem, security and recovery. This was also noted by Roberts.[3] The extraordinary shockwave born of a sudden shift to a status of physical vulnerability often shatters one's self-assurance. We submit that this is clearly operating in cases involving hemophilia-equivalent patients, particularly if they are also plagued by previous and imminent errors in judgment. This dual reduction in body image and self-confidence could well be exacerbated if the "machismo mystique" were operating, particularly if the person also knew that (1) small capillaries of the brain could break at the slightest bump, causing hemorrhage and internal bleeding, and (2) reduction of cognitive abilities could also be a result.

Everyday life requires degrees of risk taking that, as shown by Alby,[4] may cause "necessary risk" to suddenly change in meaning. Overprotectiveness due to hemophilia causes one to become passive instead of assertive (also see the discussion of adjustment problems within the family sphere posited by Salk, Hilgartner and Granich[5] in families of hemophiliac children). However, it must be noted here that, unlike our patients, the hemophiliac person during childhood and adolescence has the time to receive special preparation for his adult professional life.[6]

A physician handling a case requiring the use of anticoagulants is in a double bind. Whether he selects sodium warfarin (long-term and oral) or heparin (short-term and intravenous), he faces the dilemma that "too little" does no good and "too much" produces bleeding.

Hence, the hemophilia-like state often induced by the chronic use of anticoagulants requires the collaborative effort of management of the many aspects of hemophilia afforded by a team effort of various specialties. This was first insisted upon by Hirschman and Ely (1972)[7] and strongly concurred with by Griffith and Hero (1979).[2] Here, too, it is most certainly advocated.

Critically important is the intelligent and rational sharing of this information with the patient, his family, colleagues and employers. This is not deleterious or unfair to any of those mentioned. Indeed, those patients counseled expressed immense relief that they were not "going crazy" and were "feeling out of phase" for good reason. Those families and employers so advised expressed understanding in place of confusion and irritation, particularly when shown that discontinued use of the anticoagulant, due to exercise and diet control, apparently not only returns the patient to normal, but also that replacing "snap" decisions with a well-thought-out approach usually precludes much of the problem.

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The Rights of Adult Adoptees

TO THE EDITOR: I am both a medical student and an adoptee who just last July met my biological family. Naturally I was very interested in both the July article "Adoption: Pediatric, Legislative and Social Issues"[1] and the response by Xavier Gonzalez, MD, published in October.[2] I wish to respond briefly both to the article and in particular to an issue raised by Dr. Gonzalez.

I wish first to commend Drs. Davis and Brown for a very informative *and* enlightened article. There is almost no facet of adoption that is not today either a focus of controversy or in a state of flux. Primary care physicians, by the very nature of their profession, cannot help but be affected by current adoption trends.

I especially appreciated the statements by Drs. Davis and Brown concerning the adoptee's search for his (or her) biological family. I completely agree that such searching is "a quest for information . . . [and] not an attempt to find new parents."[1] My own adoptive family upbringing was very traumatic—with a divorce, child custody battle, my adoptive mother's and sister's deaths, and much bitterness. I lacked a sense of security and well-being for most of my childhood and bore emotional scars for many years. Yet *despite* all these problems, I never once entertained the thought in my search that I would be "coming home"—so to speak—to my *real* family. I was looking for biological identity and medical information, and nothing more. My family, for better or worse, is the one that raised me, and this is the view shared by all the adoptees I have met. Emotionally it simply cannot be any other way.

I wish finally to address an issue raised by Dr. Gonzalez in his letter to the editor: the natural parents' right to anonymity. My question is this: Who really has the right—for whatever reason—to permanently deny a human being his biological identity? I doubt that advocates for absolute anonymity realize that until very recently adoption proceedings commonly did not transmit even minimal medical history information to the adoptive family. In my own case, I discovered that my grandmother has systemic lupus erythematosus and that there is a general family history of respiratory diseases. I was glad to become aware of both facts. I have also spoken with another adoptee who stopped bearing children prematurely because she could no longer withstand the uncertainty of possible genetic problems. If for no other reason, certainly the need for medical information (good or bad) is sufficient and overriding justification for direct contact with biological parents by an adult adoptee.

I personally believe that natural parents have a right to general anonymity. I do not concur, however, that they have a similar right on the basis of anonymity to permanently deny knowledge of family background, medical history and siblings to an *adult* adoptee. Once direct contact has been made, the biological parents have the right to reject a relationship (and vice versa); but to deny them the basis for that first contact, appealing to the right of anonymity, seems to me to deny the more basic right of any human being —that of knowing where one originally came from.

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More on Neurosyphilis

TO THE EDITOR: Dr. John R. Hotson's review of modern neurosyphilis[1] in the September issue was a well-organized survey of this disease. However, Dr. Hotson's criteria for diagnosing neurosyphilis cannot go unchallenged because they reflect a logical flaw in contemporary attempts to analyze the clinical profile of this illness.

It is generally accepted that a patient with a reactive serum FTA-ABS (fluorescent treponemal antibody absorption) test has had syphilis at some time. The question is, when neurologic dysfunction develops in this patient, is he a victim of neurosyphilis or of a concurrent, unrelated neurologic disease? At present we have no adequate way of distinguishing between a "modified neurosyphilitic syndrome" and a nonsyphilitic neurological illness occurring in a person with cured or latent syphilis. The investigative technique used by Dr. Hotson and others[2] of retrospectively selecting